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ABSTRACT

Family therapy is well-acknowledged as an effective mode of psychotherapy. Clinical and empirical data, intervention techniques, and training and supervision issues appear increasingly in psychological, psychiatric, and social work journals. However except for a few community-psychology reports on the use of indigenous workers, little has been written on the training of paraprofessionals, and specifically undergraduate preparation for family-intervention work is not readily available. An applied-psychology major is one response to the scarcity of professional expertise and accessible resources for the education and continuing education of mental health practitioners and paraprofessionals in rural areas or impoverished urban areas. Undergraduate education and training in family therapy prevention and intervention prepares paraprofessionals to work effectively with families in a variety of mental health settings. It is proposed that four family therapy theoretical models be taught: client-centered, psychodynamic, structural, and strategic. Skills are taught and practiced in improving communication, restructuring, and designing and implementing strategic interventions. Education and training are accomplished through coursework, discussion, role-plays, small group work, and videotaping. Student internships during the final academic quarter provide opportunity to work with actual clients, usually as part of therapeutic teams. The nature of supervision varies according to student need, learning situation, model framework, and case complexity. (ABL)

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Paraprofessional Training in Prevention and Intervention in Dysfunctional Families

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Abstract

Course preparation, treatment skills, training methods, and supervision issues for an undergraduate family-therapy training program for paraprofessionals are proposed. Rationales are given for program goals, content, and procedures. Examples of student work are provided.

Paraprofessional Training in Prevention and Intervention in Dysfunctional Families

Family therapy is well-acknowledged as an effective mode of psychotherapy. Clinical and empirical data, intervention techniques, and training and supervision issues appear increasingly in psychological, psychiatric, and social work journals. Except for a few community-psychology reports on the use of indigenous workers, however, little has been written on the training of paraprofessionals, and specific undergraduate preparation for family-intervention work is not readily available. This article describes undergraduate preparation for effective family interventions by paraprofessional staff.

An applied-psychology major is one response to the scarcity of professional expertise and accessible resources for the education and continuing education of mental health practitioners and paraprofessionals in rural areas or impoverished urban areas. Most college and university undergraduate majors consist of a liberal arts basic curriculum and didactic courses specific to the major. An undergraduate major in psychology, however, can combine a core foundation of didactic courses with experiential, practical, skill-building courses in family therapy prevention and intervention for undergraduates who want paraprofessional training in family psychology.

Students are taught basic concepts, issues, and skills in

family therapy, and practice within simulated or actual family-treatment settings, under the guidance of and in the presence of, the supervisor. Training and practice occur initially in academic classes with volunteer "clients" (classmates, subject-pool volunteers, drama majors, college/university and community staff, even interested community members), then in internships in mental health facilities during students' final academic quarter prior to graduation.

It is not as presumptuous as it may at first seem (Christensen, Brown, Rickert, & Turner, 1989) to believe that undergraduate training alone can produce effective family workers. Not only has paraprofessional training in general been shown to be effective (Durlak, 1979; Lorion & Cahill, 1980), but also, although concepts and techniques of several major family therapy models are taught, the aim is not to produce master therapists but to produce mental health workers competent in family psychology.

Undergraduates can be taught basic interviewing and crisis-intervention skills, of course. They can also learn to recognize when parents are not assuming or effective with parental authority or when a parent is treating a child as a parent, the existence and effects of maladaptive coalitions, and what interaction sequences are recursive. They can learn to have family members talk with one another, they can learn to implement specific change strategies, and they can learn to consolidate and

test changes. If students can take families beyond homeostatic boundaries through basic constructive actions, they can be effective in family-intervention work.

The undergraduate years are in fact an ideal time to begin family-intervention training. Students are already aware of, and often stymied by, the handicapping nature and consequences of family problems, and are themselves often within a developmental transition. Framo (1979) considers undergraduates more open to systems conceptualization because they are not yet grounded in intrapsychic psychology. In addition, the undergraduate learning situation is usually less traumatic than the graduate one because pressure to do well and/or not to make mistakes is typically felt less intensely at the undergraduate than at the graduate level. Although some anxiety is generally present in any new or risky situation, less of a student's identity, or career-ability expectations, is bound up in each class performance. Class performances for undergraduates are tasks for one class in a variety of content areas, and career possibilities are still under active consideration. For graduate students, class performances are integral to a specialty area already heavily invested in emotionally, financially, and academically, and must be approved even before progression is permitted.

Grading expectations are appropriately at beginning levels; therefore, the emphasis is on the value of learning through the experience. Motivation and investment in the work are typically

high. Students can allow themselves more tolerance for making mistakes and often take more opportunity to risk something new or difficult because they perceive the situation more as a learning experience than an evaluation. Since students' first "clients" are volunteers, and these functioning student or staff volunteer clients are not overwhelmed by the situations they bring to the interviews, students are less afraid of having negative effects on clients or missing indications of life-threatening crisis. Even when the problems discussed are real for the client volunteers and in fact serious ones, the definition of the experience provided by being in a class setting rather than a therapy room has the effect of allaying anxiety for both client and student therapist during the work.

Often undergraduate students can in fact be permitted more autonomy than graduate students, and feel more comfortable using it, both because skill goals are appropriately small and specific and because mistakes or missed opportunities the supervisor allows to go uncorrected are not as potentially serious with volunteer clients. If a student misses a message or opportunity, does not do something effectively or at the appropriate time, or does not follow an instruction or presession plan, s/he is given the information and practice needed after the session, and new opportunity later. Interruption by the supervisor during the working session is restricted to the most important incidents. This allows the beginning student optimally coherent

concentration within the session as well as the experience of increasing competence and self-esteem as s/he perceives the nature of the supervisory comments to change as skills develop (Grater, 1985; Hess, 1986, 1987). In young people relatively inexperienced with the joy of work-related mastery, this can be an especially significant developmental experience. It also supports the individuation and autonomy valued by most youth at this period in their lives.

A family-therapy program within an applied-psychology undergraduate major, created (Bayer, 1984) for a four-year state university, is described briefly below:

I. Educational Methods
    A. Didactic instruction
        1. Family-systems theory
        2. Principles of growth and change
        3. Developmental issues and transitions
    B. Skill-building
        1. Effective communication
        2. Problem-solving
        3. Specific techniques
    C. Role-playing
        1. Crisis management
        2. Specific interventions
    D. Therapeutic teamwork
        1. Observation

2. Engaging with the family
3. Specific tasks

II. Treatment Skills

A. Establishing a working relationship
1. Involving the family
2. Linking with referrals and social support
3. Joining the family

B. Clarifying family difficulties
1. Defining the problem(s) and family expectations
2. Determining family structure, process, and interaction patterns
3. Identifying circularity and homeostatic sequences

C. Strengthening/changing the system
1. Restructuring and task-setting
2. Altering interaction patterns
3. Facilitating open communication and constructive emotional expression
4. Encouraging greater personal and shared responsibility

D. Consolidating and terminating
1. Considering changes made and what would bring the problem(s) back
2. Addressing transition issues as paralleled

by separation issues in terminating

3. Following up

III. Supervision Issues

A. Peer review

1. Inservice/class feedback

2. Staff-meeting feedback

3. Therapeutic-team feedback

B. Treatment-team opportunities

1. Presession planning

2. Task assignment for the working session

3. Postsession debriefing

C. Supervisor-paraprofessional relationship

1. Mentor

2. Example

Treatment Skills

Since readers are familiar with the systems epistemology and major family therapy rationales, concepts, strategies, and terms, the above outline will not be described in full. Readers are aware, for example, that a rationale is given for involving the family rather than working with a single individual, and that techniques for joining, for engaging resistant families, etc., are offered in detail by various specialists (e.g., Anderson and Stewart, 1983; Minuchin & Fishman, 1981; Stanton & Todd, 1982). Teaching paraprofessionals to link with social support and

referral networks is important to mention, however, because (1) fewer agency and treatment options are available in rural or impoverished urban areas, and many traditional models and facilities that are in place are rejected as alien to subcultural values, and (2) the safety and health needs of families and individuals are often profound in dysfunctional families, and must be quickly assessed and remediated as necessary.

Teaching paraprofessionals to help families within one of the first tasks, defining family problems and expectations, permits many basic issues to become clear to students. The fact that family members often have radically different perspectives and wishes is one. That the people in the family may never talk with one another, and may in fact try to talk exclusively with the student therapist or not at all, is another. Supervisors often point to the need to remind trainees to notice and include the whole family, and to get them talking with one another constructively (e.g., Byng-Hall, 1982). The value of being systems-oriented rather than linear or intrapsychic in focus or conceptualization can become beautifully clear in this early exercise.

Students examine family interaction to assess family structure (hierarchies, coalitions, rules, boundaries, etc.), and repetitive communication and behavior sequences that protect homeostasis and maintain the problem(s). In a theories class, for example, students observe videotapes of actual dysfunctional

families, then write analyses following three family therapy models--psychodynamic (Ackerman or Bowen), structural (Minuchin), and strategic (Mental Research Institute/Palo Alto group, the Milan team, or Haley/Madanes). Students are asked to indicate what they observe, hear, and hypothesize in terms of the foci of emphasis in the three models.

In the psychodynamic model, this might include multigenerational conflict and/or role repetitions adopted by/assigned to various family members, family triangles, and uniformity in thinking and acting indicative of "undifferentiated ego mass" (Bowen, 1981), for example. In the structural model, data attended to would offer subsystem information; sources, types, and uses of power; and rules governing boundaries and power alliances. In the strategic model, the metaphoric value of a symptom, the communication styles of family members, the responses to the problem which maintain it, and the means of denying or negating new information might be noted. Again, these are examples, not comprehensive descriptions of data or models.

The client-centered model (Rogers; see also Levant, 1983) is also taught in the family-systems theories class and used in the interventions class. It is not used in the videotape analyses because the concepts and skills have been emphasized in several prior courses as basic to therapeutic intervention. Client-satisfaction levels with family therapy have been shown to vary with the extent family therapists retain their "nonspecific"

therapist skills (Stolk & Perlesz, 1990). Student therapists in this program begin work with individuals or families by encouraging direct, affectively honest communication, ability to take the perspective of another, and balance or greater equality in relationships.

In family-intervention practice and work with families ready to experience constructive change, once upsetting issues are identified, the goal for the family is to work toward resolving them rather than simply reacting to them. Together the family and student therapist learn to talk with and question one another without blaming or asking why. In general, they (1) acknowledge the issue(s); (2) clarify what makes each issue problematic and difficult to talk about, the feelings engendered in family members, and the impact it has or is feared to have on the family; (3) explore what the family would like to have happen, what has been tried so far and with what results, different responses the family and family members might make now, and possible consequences of those responses as well as of lack of response; (4) examine potential resources; (5) plan family action(s) acceptable to and contributed to by all family members, discuss and amend that(those) as necessary in future sessions, and express and share feelings arising with new experiences; and (6) plan and implement additionally as progress is made until resolution is satisfactory.

If the family cannot or will not utilize these

opportunities, such as in rigid, child-focussed families or chaotic, multiproblem families, one of the other major models is selected. Students are taught the psychodynamic model, including some intervention techniques, for its historic value and the current uses of the models of Ackerman and Bowen, even though they may seldom use the techniques. The psychodynamic model is used less frequently because some supervisors (e.g., McDaniel, Weber, & McKeever, 1983) believe the model requires greater theoretical sophistication and ability to translate theory into practice than the structural and strategic models, and is therefore less suitable for beginning therapists. Many therapist supervisors (e.g., McGoldrick, 1982; Papp, 1980) recommend structural changes and facilitation of open communication with families that can tolerate some change, and strategic interventions with severely dysfunctional homeostatic families. For clarity of rationale in discussing cases and direction in designing interventions, the models are kept as conceptually distinct as possible; however, distinctions are still being drawn (e.g., Fish & Piercy, 1987; MacKinnon, 1983) and integrations are still being suggested (e.g., Lebow, 1984; Liddle, 1984).

Student therapists select intervention models following assessment and conceptualization of the nature of the family problem(s), structure, and interaction. The presenting problem may be, say, teenage pregnancy, and the session may reveal that the father as a teenager got one girlfriend pregnant but did not

marry her, later repeated this with his daughter's mother and married her, then divorced her and left the family to do the same thing with the woman with whom he is currently living. The mother might acknowledge wanting to get pregnant when she and her ex-husband were dating, to help ensure marriage. Genograms or family-of-origin histories for both parents may reveal similar events in previous generations.

If it is hypothesized that the pregnant daughter has always felt an unwanted "accident" and/or a tool of manipulation, yet also feels compelled to live the same experience as her parents precisely because it has never been resolved by the family, a psychodynamic approach may be used by the student therapist. Any multigenerational repetitions would be addressed directly, and individuating the family members from one another and from ancestral roles and functions would be attempted. Interpretations would be made, with behavioral and historical confirmation pointed out, and another resolution sought to the conflict, a resolution which would include expression of powerful, suppressed, attendant emotions. "Resistance" would be expected and dealt with openly, with direct (but caring) confrontation and challenge.

When the precipitating factor escalating a homeostatic but normally functional family into disabling dysfunction is, say, potential or recent change in family membership, role, status, or function that affects family rules, boundaries, or hierarchical

organization, a structural approach might be decided upon. An enmeshed family may be refusing individuation or increasing autonomy to a teenager, for example, or to a homemaker contemplating entering or reentering school or work, or to a wage-earner in "midlife crisis." A disengaged family may be denying a teenager needed limits and guidance, or spousal intimacy may become impossible when a grandparent comes to live in the home.

The student therapist would need restructuring skills to engage a disengaged parent, disengage an overinvolved one or involve an overinvolved parent in a negative manner, put the parents in charge together, etc., according to family need. If change proposed in a straightforward manner is resisted, a rationale might be given for staying the same, to see if the resistance could then itself lead to family-initiated change. If the symptom is being used as a source of power for a family member otherwise feeling powerless, an intervention altering the family power structure in a more constructive way might be designed.

A strategic approach might be taken if, say, a child's symptom metaphorically reflects a marital struggle, or "protects" a parent from something believed by the family will overwhelm the parent and disintegrate the family. The task(s) would be designed to change, by challenging the rules that govern the system, the ways in which family members interact and

communicate--a process rather than structural change. Positive connotation of what they do, however, would allow the family not to have to defend it or keep doing it to show that they can, and leave them available to do something else.

Skills needed to alter interaction process include prescribing or escalating the symptom, such as within a game or pretend situation; countering resistance with methods such as confusion, communicating in a one-down position, or creating a "benign ordeal" (Haley, 1977); shifting frames of reference from negative to positive, such as by seeking acceptance of a very tiny goal that would signify very small but important improvement to the family; etc.

Although students are required to demonstrate academic and practical understanding of four theoretical models of family therapy in the theories class (client-centered, psychodynamic, structural, and strategic), they are permitted either to work consistently within one model or to work from their learning of a variety of models and interventions in the interventions class. This is consistent with general acceptance within psychology currently that (1) no single model is universally superior but many practitioners work best within a model consistent with their personal ideologies and most effective skills; (2) abilities and flexibility within several models help therapists be effective in contexts often vastly different from their own. Students are encouraged to develop some ability to use interventions from each

model even if they prefer working within a single framework once they know what it is they prefer in the model selected, and why.

Another program decision concerns whether or not to involve students in specific exercises working on their own families of origin. Although the value of this is noted by therapist supervisors such as Bowen and Satir, the option for this, like the option for personal (individual or family) therapy, can be left to the student to initiate independently if desired. Three reasons support the choice not to involve students in specific exercises concerning their families of origin: (1) Priorities for use of the limited teaching time available are held to be higher for scheduling intervention-skills training than for scheduling attempts at self-understanding, implicitly conveying that they will do this on their own or ask for guidance if/when it becomes important; (2) respect for each student's priorities, pace, and method(s) for self-exploration; and (3) known disadvantages of "interpretations" not strategically timed. Over a recent ten-year period, use of personal therapy in family therapy programs has declined (Nichols & Nichols, 1990).

Training Methods

Classroom instruction includes both didactic instruction and skills practice. Traditional classes in introductory psychology, abnormal psychology, personality and assessment, learning theory, behavior modification, human sexuality, human relations, and

group processes provide much information relevant to family work. Students can also choose electives from among courses such as child psychology, juvenile delinquency, adolescent psychology, psychology of adult life, criminal behavior, chemical dependency, and death and dying. Among other things, these courses cover developmental transition issues (physiological, cognitive, psychological, and interpersonal characteristics in various periods of growth, and both adaptive and maladaptive psychological and behavioral responses to difficulties, etc.) and sociohistorical changes such as effects of different family compositions, effects of different child-rearing practices, sex-role stereotypes vs. androgeny in parents and children, and changing societal and personal values.

The required courses specific to working with families within a systems epistemology cover the major theoretical models, as mentioned above, including assessment and intervention design. Practice designing interventions from all four major models is required; practice implementing interventions from all models is encouraged.

Skill-building classes consist of courses in introductory therapeutic process, basic interviewing, crisis management, and family systems interventions. A variety of learning modes are used--class discussion, work in small groups, in- and out-of-class role-plays (sometimes as cotherapists), and discussion of audio- and videotapes both of student role-plays and of actual

families. Generic skills in communication, negotiation, conflict-resolution, problem-solving, facilitation, expression of emotion, and crisis intervention are practiced, then skills specific to certain client problems (e.g., chemical dependency) or responses (e.g., "resistance").

Although didactic psychology courses most often imply an intervention focus primarily on the individual, most courses within a family-therapy training program for paraprofessionals attend to both individual and family concerns but focus interventions on the family (or community) system. Each course in the training builds on previous courses. Feedback from the instructor, class, and therapeutic team (where available) is extensive.

Teamwork is highly valued in learning, doing, and providing feedback to others. Class and small-group discussion of case and task variables, practice with other students, discussion after sessions (class role-plays, videotaped sessions, etc.), and peer ratings are significant. Benefits include the variety of perspectives and ideas, facilitation of cooperation and interdependence (which later becomes modeling for families as well), attenuation of anxiety and defensiveness, greater opportunity for interpersonal learning and flexibility, and high program camaraderie.

The class or small group quickly conceptualizes itself as a therapeutic team and works together to answer questions both

specific (e.g., What is the problem here?) and general (e.g., How do we arrive at hypotheses?); design interventions (e.g., What data do we need? What is minimally needed to effect significant change?); and evaluate results (e.g., If the intervention failed, what should/could have been done differently? If it succeeded, what made that intervention work here?). The team also picks up on information missed initially by the student therapist(s, if cotherapists), in content (e.g., historical information such as earlier deaths in the family) or process (e.g., avoided issues, repetitive themes, or interaction sequences).

The therapeutic team, including a whole class when physically present, can act within a consultant role (e.g., van Trommel, 1984), with client-team interaction as appropriate (Green & Herget, 1989a & b). The team, including a whole class, is usually seen by both role-playing and actual clients as additional support and expertise available to themselves and the student therapist(s). This reduces anxiety, which diminishes tension and distracting behavior and facilitates both concentration and investment in change. At one-month follow-up, client outcome for families with team participation has been superior to that of families without team participation (Green & Herget 1989a); at three-year follow-up, significantly greater maintenance of goal attainment has been found (Green & Herget, 1989b).

In-class, class-evaluated role-plays are quite popular.

Clients in these situations are volunteers from the class, psychology subject pool, college/university or community agency staff, or other interested people. Following each role-play, the volunteer client is asked to describe what the experience was like for her/him (1) to provide information for the therapist and class on how the client perceives, interprets, and expresses what s/he experiences, and how s/he responds to a request that s/he verbalize that experience, and (2) to provide feedback for the student therapist from the experiencing client. Openness to client feedback modifies and reinforces therapist skill and sensitivity (Truax & Carkhuff, 1967).

The student therapist is also asked to verbalize her/his experiencing of the session, which provides additional information to the client and class. Sometimes the client then leaves, after being thanked for participating; other times the client is permitted to participate in the team discussion that follows, a procedure sometimes used by family therapists as an additional client benefit (e.g., Pegg & Manocchio, 1982).

Examples of how in-class role-plays are used by students for training and learning follow:

(1) In a very basic role-play, Val, 16, and her boyfriend Jeff, 17, come in together. Both say they want neither set of parents to know that Val is two months pregnant, yet Val also says she wants to keep the baby. She believes everyone but her would want her to have an abortion, but she has a friend who

deeply regrets an abortion. She has another friend who kept her baby but says she is very poor and very lonely. Both teenagers describe their parents as not caring about them and overreacting to everything. Jeff says he does not want the baby or marriage; Val says she and the baby will make it on their own.

Following the role-play, the class discusses (1) how to inform the clients of their rights and options, and the therapists' responsibilities regarding confidentiality and referrals; (2) how to explore with the young people (a) their feelings and reactions to the situation ; (b) the nature of their relationship and commitment to it; (c) their understanding of the situation and the potential consequences of various options; and (d) available resources--for instance, could the parents possibly be helpful, are there others who are important in their lives, what group(s) or agency(ies) might provide various kinds of support, are health and safety needs being met, etc.; (3) how to engage the participation of the parents and facilitate constructive problem-solving if in fact the parents are as Val and Jeff describe but the young people ask the therapists to help them "break the news" to them; and (4) how to respond constructively to intense emotions, distorted perceptions, poor coping skills, or unrealistic expectations, and still be able to prioritize what needs to be done, in small steps, and create ways to accomplish this with the clients. (At this point, for example, possible multigenerational conflicts or symptom

expression, family dynamics, homeostatic patterns, etc., are not under discussion.)

(2) A woman of forty walks in, sits down, and says, "I'm mad at telephones." The class goes from initially feeling impatient that someone would come in with such a "bizarre" or "trivial" problem, to awareness that communication is the issue, to realization that the stated problem is really a rather elegant metaphor for communication problems with her husband, with whom she is not direct and who, also indirectly, gives signals that he does not want to hear her. The wife speaks constantly (on the telephone) but is not heard (by the husband) because she is not saying what she wants to say (speaking only to her husband's customers). Yet she knows she has the power, if she wants to use it and suffer the consequences she anticipates, to ruin her husband's business through her use of the telephone. The interference in their relationship that she feels comes from his business is what she seems unable to communicate about with him.

Students change from suggestions for how she could get out of answering the telephone (suggestions she carefully negates one by one anyway, since they are all irrelevant to the problem) to helping her use the telephone "problem" as a way of opening discussion with her husband about their relationship. If this direction does not lead to freer communication and constructive change, the couple will be invited in for further assessment, hypothesizing, and intervention.

(3) Pete and Jenny, a husband and wife in their early thirties, come in fighting. Pete angrily reports that ten days ago he was arrested for driving under the influence (DUI), that "it was just one of those things," that Jenny is unreasonably upset about it, and that she has refused sexual intercourse since it occurred, which she does at every opportunity. Jenny ignores his attacks and protests to the cotherapists that he had expected her to come immediately to bail him out of jail. Pete denies that he was even speeding when he received the DUI and charges that immediately bailing him out would be nothing more than "support" to be expected of a wife. Jenny tells him he makes her furious and that he has the problem--drinking. He reiterates that marriage to him means support and that she is the problem because she fails him repeatedly.

The therapists interrupt the defense and attack/counterattack sequence only to discover a larger interaction sequence involving both families of origin: Pete has stopped drinking several times before, and both have been quite happy with the level of marital intimacy; however, these periods only occurred as the middle part of another cycle, involving Pete's widowed mother, who has predicted noisily and frequently all through the years Pete and Jenny have been together that Jenny will never be satisfied with him and inevitably will leave him, and Jenny's parents, to whom Jenny is determined to prove that Pete is not what she is currently and in the habit of accusing

him of being, to validate her decisions as an adult, such as marital choice. Within moments of revealing their parens' views, Pete and Jenny are talking divorce.

The role-play illustrates several feedback loops and interaction patterns helpful for the class to recognize, and provides opportunity for them to design hypothetical interventions to (1) accomplish "standard" goals (e.g., deescalate, set limits, focus, discuss things like what might signify "support"); (2) redefine the problem (e.g., the couple are very much in love or the marriage never could have survived so many years of parental doubts on both sides but, since they also love their parents very much, who are not yet ready to let them go, they demonstrate through the facade of having a shaky marriage that they can return to their families of origin, through divorce, if they are badly needed; (3) enable small, progressive steps toward the couple's goals of decreased drinking and increased amorousness (e.g., utilizing things like their shared fondness for dares and bets), but including also interventions to prevent future effectiveness of the sabotaging interaction with the two families of origin (such as by suggesting to Pete and Jenny that they maintain the pretence of having a shaky marriage as reassurance to their parents, until such time as the parents realize on their own that Pete and Jenny would always be reasonably available to them).

Supervision Issues

Peer feedback, as mentioned earlier, has demonstrated great usefulness in paraprofessional family-therapy training, perhaps in part because of the nature of autonomy issues typically important to this age group. Advantage of peer review and evaluation include:

(1) Although many suggestions are given, the student therapist remains in charge and can select or refuse or alter suggestions. S/he is seldom directed to do something by a supervisor, and does not feel obligated to do something simply because it was suggested, whether by classmates or the supervisor.

(2) Varieties of concrete wording examples are offered, and rationales are often briefer and more concrete than supervisor explanations. For example, a student therapist asks how to respond to a family member's "obnoxious blurting out of her own reactions to everything in the session." She selected from student replies, "Your eagerness to say how you feel suggests a lot of investment in working this out as a family. It is clear you know how important it is for each person to say how he or she feels" (slight emphasis added). Another student therapist, unfortunately trying her best to get a client to "be happy" (Watzlawick, 1983), complains that she can not get past the client's "morbidizing" and rejecting of every avenue or suggestion. Another student says, "Tell her she is talking as if

she feels at a dead end. If you never show her you have heard what she has been saying for a half-hour, you will never get her to look at whether or not her assessment of the situation is realistic." Not only is this a simple but basic reminder to acknowledge feelings and content, but the choice of words ("dead end") is metaacknowledgement of several of the client's earlier vague verbalizations about a prior suicide in the family. (The supervisor also suggests that the student therapist look at the client-therapist feedback loop and at the systemic value of the woman's depression within the family.)

(3) Weight or frequency of attention given by the group to the importance of a client communication, or to the impact of a therapist communication, can have more influence on the therapist than a supervisor's comment, even repeated. In this way written peer ratings are also helpful, in evaluating student therapists. Low ratings from several students, or frequent comments regarding a single dimension or skill, are hard to ignore. (Consistently high ratings are also!)

(4) Many process comments are offered. For example, "The more the mother acts helpless, the more the son takes over"; "The daughter keeps interpreting your comments as criticism"; "The only thing that stops mom and dad's bickering is junior's whining"; "Notice how every time the mother listens attentively or agrees, the father looks away?"

(5) Process intervention suggestions are also plentiful.

For example, "Ask her whom she most helps by doing that so often"; "Stop helping them avoid the issue--at least name it"; "You could praise his family loyalty and dependability here"; "See if that conflict is really a disguise protecting Dad from conflict with her"; "Tell her to make it happen--don't let him do it for her."

Another source of peer supervision is from the students taking the preinternship seminar during the quarter preceding internship. The comments of preinternship students who have finished most of the courses are helpful to junior students, especially since supervision issues are discussed in the seminar to prepare preinterns for the more intensive and advanced supervision they will shortly receive. The experience of role-playing a supervisor also helps preinternship students take the perspective of a supervisor and promotes greater understanding of what supervisors seek to accomplish.

During a student's internship, staff feedback, individual and group supervision, inservice training, and team meetings can be invaluable, and offer the advantage of relating to actual cases. Student interns are almost always part of therapeutic teams, not practicing as primary therapists until well into their internships, if at all. No intern takes a case until s/he feels ready. Supervision is provided at the facility by the facility supervisor(s), and through visits and telephone discussions by the college/university supervisor.

Supervision of presessions, sessions, and postsessions in courses helps prepare student therapist for working on therapeutic teams. Presession planning by the therapeutic team focusses on the small goals for that session and how they fit within the larger goals and the system functioning. Simple as it may sound, it is important to keep reminding students that each problem must be identified and defined before a solution is attempted. Prioritizing tasks is also important; for instance, certain conflicts must be resolved by the family before others can be acknowledged or addressed.

Usually real or simulated interventions are deliberately simple in design; however, sometimes, especially to reinforce the helpfulness of a systemic view, a comprehensive evaluation and intervention is requested of students. The following complex intervention was designed by a class for a family in which the identified patient is a nine-year-old boy, John, who "clowns" (family definition) to the point of being bizarre so frequently that he has been labeled psychotic and hospitalized. Sometimes while he is being bizarre, he is also aggressive and/or self-destructive.

John's older brother has been in violent fights with other teenagers, and has been in trouble several times for vandalism. John's sister, Lucy, serves as a very busy mediator among family members and is a good student in school. The mother in this family is frequently depressed; John's "clowning" is the only

thing that cheers her up. She hints that the depression may have something to do with John's father, who is disengaged from everyone in the family, although she says "feeling bad just goes with the territory" of being a mother. Despite the massive inappropriateness of each family member's standard behavior within this system, each extols the family unit and promises fervently to do anything possible to "help John get well so he can come home."

For the initial intervention, a task is designed for each family member. Mother is asked to continue to be depressed. When John responds by "clowning" to cheer her up, she is to ask him not to do that because mothers can handle their own problems and deal with their own feelings. She is to convince him it is a disservice for him to distract her from doing so, that she is busy enough as it is. He is not expected to believe her at first, because this is a change, and so may not go along with it and may try to cheer her up anyway. No matter how much he clowns or how bizarre he acts, she is to remain depressed. In fact, she must be as depressed as possible so that she can really convince him she means what she says. (The mother is adept at nonverbally negating whatever she says verbally.) She is told that she is being given the most important assignment because only a mother could manage something so demanding and difficult.

John's father is asked to help John by helping his wife remember to be depressed and to be firm in her message to John.

No matter how sorry the husband may feel for her, he must try to help her feel more depressed than ever before and remind her to insist to John that she is going to handle it herself. John's father is also to take John aside once each evening and support both the mother's message to John and John's maturity in being able to let this happen.

Cut off from her source of avoiding depression, and perhaps irritated by being kept on task by the person she believes causes much of it, John's mother may well turn angrily on her husband. If she does have issues with him that need attention, open fighting may at least provide a way to begin and a way to address the marital relationship in therapy. Her husband may actually sympathize with her once John is no longer between them. He may find new opportunity to relate to John as well, as a father.

The brother is asked to help John deal with his occasional tendency to be aggressive by showing John alternatives to destructiveness, like hitting punching bags or throwing darts or horseshoes. This may help the brother with his own impulse control and strengthen the sibling subsystem. Lucy can be taken out of the middle of every subsystem by changing her mediator role to a role of recorder. She is asked to keep track of each time a family member performs an assigned task, and each time one does not. She is not to comment or intervene in any way--simply to record it all and bring the record to the next session. She is to include herself, of course, promoting self-reflection also.

John is asked to help all of the family members help him, by cooperating as they carry out their tasks.

Even if hypothetical interventions can not be evaluated through implementation, they serve the class as helpful exercises in thinking through various family members' contributions to the system and to problem maintenance, and in involving all family members in initial constructive change.

Postsession discussion activities can range from attempting to decide what a single interchange means to pointing to manifestations of change. The former could not be more exquisitely illustrated than in Scheflen's (1978) classic piece on a young woman's smile. With exposure and practice, students are able to follow and develop their own systemic and paradigmatic thinking.

Examples of change that student therapists have pointed to include specific changes predicted by certain models of family therapy and general changes toward more constructive interaction and relationships. Examples of the former include:

(1) Breaking a former rule, such as not to talk about a taboo subject or not to express anger.

(2) Altering a boundary, such as through new parental limit-setting.

(3) Altering an interaction process, such as a mother's not taking a one-down position to a father, or an interaction sequence, such as a father's not intervening when a mother

disciplines a daughter with the result that the daughter's acting out no longer restimulates helpless behavior by the mother and criticism of the mother and daughter by the father.

(4) Someone's refusal to continue playing the game or return to homeostasis, such as by stepping out of a role, metacommunicating, or allowing a power change (e.g., letting someone win who is not "supposed" to).

(5) Sudden honesty in communication or expression of affect where it had not been offered/available before, such as sharing genuine feelings or speaking about oneself rather than about another family member or the family as a unit.

Examples of general change toward improved communication and relationships include:

(1) Fewer crises, more effective coping, and quicker recoveries.

(2) Less over- or underinvolvement, less rigidity, fewer recriminations, and less revenge-seeking.

(3) Greater cooperation, sensitivity, spontaneity, and intimacy; less scapegoating; and fewer lapses in agreements.

(4) More direct communication and freedom of expression of both thoughts and feelings; fewer cutoffs, contradictions, denials and undoing, and irrelevancies.

Much of postsession discussion involves identifying both effective and ineffective therapist-family interaction and integrating the new information into continuing assessment and

treatment planning. Peer, staff, and/or supervisor comments are freshest when the session is observed live or through a one-way mirror; however, analysis of videotapes allows for full examination of any interaction. When one mode of supervision is not inherently superior to another--for example, through supervisor characteristics operating within one setting but not in the other--no significant differences between delayed and live supervision have been found in ability to acquire and retain selected family therapy skills (Fenell, Hovestadt, & Harvey, 1986).

In discussion and exploration of videotapes, students can see for themselves what was "really" happening, recognize metacommunication, and perceive sequences and patterns. Student therapists can also see and explore how they did things like lead people away from issues, offer information on their own perceptions and feelings in those moments, and now conceptualize additional intervention possibilities.

Once a student therapist has demonstrated basic competence in family intervention, videotaping or uninterrupted/seldom-interrupted live supervision better allows for development of a student therapist's own style than bug-in-the ear or telephone supervision, because it follows therapy and is not intrusive in the moments that patterns, roles, functioning, etc., are being recognized or therapeutic interventions are being mentally structured or attempted. While telephone supervision may "reduce

the time lag" (Wright, 1986) between family stimulus and therapist intervention response, the cost in therapist experiential learning and personal mastery would appear to outweigh that possible benefit. The importance of not "undermining" trainees has been supported in recent supervision outcome research (Lewis & Rohrbaugh, 1989).

Supervision helps the student therapist avoid becoming a part of the dysfunctional system and effectively combat powerful homeostatic interaction in the family; success results in more constructive family functioning. The supervisor teaches, facilitates, collaborates, and enacts various kinds of process with student therapists. The primary responsibility of the supervisor is to keep the student therapist becoming increasingly competent with the family, just as the student works to facilitate family development. The supervisor must be able to move flexibly and constructively within the family-therapist-supervisor system, to metacommunicate, and to evaluate objectively.

Questions are both conceptual and focussed--for example, "What is important about this issue?" "What consequences of that action does the family fear?" "What would change in the family if what is being discussed took place?" Students learn to recognize, say, that a husband fears that the potential role change if a wife returns to school will disintegrate the spousal/family equilibrium, and sudden realization of the

availability of a new source of power is creating considerable conflict in the wife.

Process interventions are elicited from the group by the supervisor (e.g., "What focussing strategy might be used here to stimulate discussion on the issue being avoided?") or distinguished for the group as they occur (e.g., "Now you are giving suggestions directed not only toward problem-solving the metaphorical problem (such as ways a wife can increase or get her husband to increase her spending money) but also at the 'valuing' relationship issues the problem expresses").

Affective blocks, "blind spots" or "resistances," and inadequate skills in the student therapist can either be deal with by addressing them directly outside sessions (with both talking and acting) or by utilizing opportunities within sessions to elicit different responses from the student therapist. An example of the latter would be suggesting that the therapist request that one family member help another talk about a difficult issue and put feelings into words. This can help both family members deal with what is difficult for them, as well as benefit other family members who are present and therefore influence and are influenced by the interaction. In addition, however, the student therapist is given the opportunity to be able to facilitate this process and move beyond his/her own difficulties. Isomorphic paralleling (Liddle & Saba, 1983) is also very useful.

The supervisor helps students understand the different meaning/interpretation/subjective reality a communication has for different family members, and for the student therapist and supervisor, then how interventions must relate constructively to those subjective realities to be utilized productively. For example, a parent may say or do something a certain way because it is comfortable, familiar, "standard" in his/her world, etc. If asked, s/he would offer several reasons that s/he believes are completely logically correct. The supervisor can show students, through behavioral and other communication examples, the function of the behavior in protecting the parent from risking.

Then the supervisor can suggest that the verbal intervention acknowledge the parental reality as well as, say in this case, the teenager's reality. The student therapist can support the importance of parents' making parental decisions but also a teenager's expression of independence through distinct and separate behavior. The student therapist then encourages the family to combine these goals previously seen as incompatible into a constructive resolution. The supervisor might also help students design and implement an initial intervention to help the parent move toward similar individuation without needing the protection of living through and identifying himself or herself through the son or daughter, beginning with things such as eliciting simple personal definitions and differences between himself/herself and others.

Incongruent communication and behavior is another area with which supervisors help student therapists. Students aware of the futility of arguing about subjective realities sometimes feel angry and helpless when confronted with behavior in blatant contradiction to family definitions. The supervisor can help the student therapist draw appropriate attention to the incongruity but with appropriate neutrality and framing, such as, "Perhaps you were taking the opportunity just now to..." do what was claimed is never done, for example.

Different models emphasize different supervisory functions (coach, teacher, collaborator, facilitator, etc.) and vary on dimensions such as degree of directiveness. The flexible supervisor serves different functions at different times and is consistent within the model being used at the time.

Summary

Undergraduate education and training in family therapy prevention and intervention prepares paraprofessionals to work effectively with families in a variety of mental health settings.

It is proposed that four family therapy theoretical models be taught: client-centered, psychodynamic, structural, and strategic. Skills are taught and practiced in improving communication, restructuring, and designing and implementing strategic interventions. Education and training are accomplished through coursework, discussion, role-plays, small-group work, and

videotaping. Student internships during the final academic quarter provide opportunity to work with actual clients, usually as part of therapeutic teams.

The nature of supervision varies according to student need, learning situation, model framework, and case complexity.

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